Government of Western Australia
Department of Health
Child and Adolescent Health Service
Child and Adolescent Mental Health Service

Community Child & Adolescent Mental Health Service Referral Form

STRICTLY CONFIDENTIAL

ALL REFERRALS MUST BE MADE BY A PRIMARY HEALTH CARE PROFESSIONAL WHO HAS CARRIED OUT AN ASSESSMENT UPON WHICH THIS REFERRAL IS BASED

Community CAMHS includes services provided at the following locations
Refer to the attached Catchment Area Listing for contact details of the appropriate service to direct your Referral

Armadale CAMHS	Bentley Family Clinic	Clarkson CAMHS	Fremantle CAMHS	Hillarys CAMHS
Peel CAMHS	Rockingham CAMHS	Shenton CAMHS	Swan CAMHS	Warwick CAMHS

CLIENT DETAILS

CHILD/ YOUNG PERSON'S SURNAME: _____ NAMES: _____

IS CHILD/ YOUNG PERSON KNOWN BY ANY OTHER NAMES: _____ DOB: ____ /____ /___

GENDER: FEMALE ☐ MALE ☐ MEDICARE NUMBER: _____Ref:___ Exp:_____

CURRENT ADDRESS: _____ SUBURB: _____ STATE: _____ P/CODE_____

HOME PHONE: _____ WORK PHONE: _____ MOBILE: _____

ABORIGINAL AND TORRES STRAIT ISLANDER (TSI) ☐ ABORIGINAL NOT TSI ☐ TSI NOT ABORIGINAL ☐
OTHER ETHNICITY ☐ _____

COUNTRY OF BIRTH: _____ YEAR OF ARRIVAL IN AUSTRALIA: _____

INTERPRETER REQUIRED? : YES/ NO REQUESTED GENDER OF INTERPRETER: FEMALE ☐ MALE ☐

PREFERRED LANGUAGE: _____

CURRENT SCHOOL: _____ YEAR: _____ PHONE: _____

PARENT'S/GUARDIAN'S DETAILS:

PLEASE TICK ALL APPLICABLE BOXES

☐ MOTHER'S NAME: _____ Work phone/mobile:_____

☐ FATHER'S NAME: _____ Work phone/mobile:_____

☐ LEGAL GUARDIAN'S NAME: _____ Relationship to Child/Young Person: _____

☐ OTHER: _____ Relationship to Child/Young Person: _____

HAVE THE PARENTS/GUARDIANS CONSENTED TO THIS REFERRAL? YES ☐ NO ☐

IF OVER 16 YEARS, HAS THE CHILD/YOUNG PERSON CONSENTED TO THIS REFERRAL? YES ☐ NO ☐

REFERRER'S DETAILS: (Please write or print clearly):

NAME: _____ ROLE/POSITION: _____

Practice/ Agency name: _____ Tel: _____Fax:_____

Address: _____ Post Code: _____

Have you directly assessed the child? YES ☐ NO ☐ Date of last contact with the referred person: __/___/___

DATE OF THIS REFERRAL: ___/___/___

MENTAL HEALTH ISSUES – PRESENTING PROBLEMS: (Please write or print clearly)

Describe presenting problems, including onset and duration of problem, and frequency of concern:

_____

_____

_____

_____

_____

_____

_____

HISTORY OF HEALTH PROBLEMS: (within the context of presenting mental disorder)

_____

_____

IDENTIFICATION OF RISK ISSUES: Do you feel the child is ***currently*** at risk? YES ☐ NO ☐

Describe issues:

_____

_____

_____

_____

IDENTIFICATION OF CHILD PROTECTION ISSUES: Are there any ***unaddressed*** concerns, such as abuse, neglect, lack of supervision, homelessness? YES ☐ NO ☐

_____

_____

_____

OTHER AGENCIES/ CARE PROVIDERS INVOLVED: (Current & Previous)

1. _____ Contact person: _____ Phone: _____ When? _____
2. _____ Contact person: _____ Phone: _____ When? _____
3. _____ Contact person: _____ Phone: _____ When? _____

If current, are these agencies aware of your referral? YES ☐ NO ☐

(N.B. If reports are available, could you please arrange for these to be forwarded with the referral

FURTHER COMMENT & RELEVANT MATTERS OF CONCERN:

_____

_____

Thank you for the information provided, our Triage Clinician will make contact shortly to discuss this referral